(Date of Referral: March 23, 1999) 412-644-5754

CASE NO: 1998-LHC-698
OWCP NO: 05-91422

In the matter of

LEA ANN GREGG
Claimant

v.

U.S. MARINE CORPS, MWR
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Steven M. Birnbaum, Esquire
For the Claimant

Robert C. Kessner, Esquire
Muriel Taira, Esquire
For the Employer

BEFORE: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER

This case arises from a claim for compensation under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. 902, et seq. ("LHWCA" or "the Act"). A hearing was held before me on August 20, 1998 in Honolulu, Hawaii, at which time all parties were given a full and fair opportunity to present evidence and argument. No appearance was entered for the District Director, Office of Workers' Compensation Programs ("OWCP"). Claimant's exhibits (CX) 1-21 and Employer's exhibits (EX) 1-45 (excluding nos. 8 and 42) were admitted to the

record without objection. The record remained open post-hearing for the submission of closing briefs and proposed findings of fact and conclusions of law.

I. STIPULATIONS

The parties stipulate and I therefore find:

A. The Claimant is covered by the Act.

B. The Claimant sustained an injury on October 15, 1993.

C. The injury occurred in the course of the Claimant's employment.

D. The Claimant provided timely notice of her injury to the Employer.

E. The Claimant received treatment for her injury

II. ISSUES

The issue to be resolved is:

A. Whether the Claimant continues to require further medical care and treatment for a work-related injury, impairment or disability suffered on October 15, 1993?[1]

III. FINDINGS OF FACT

A. BACKGROUND

Lea Gregg (hereinafter "Mrs. Gregg" or "Claimant") and her husband testified at the hearing. Mrs. Gregg testified that on October 15, 1993 she was emptying five or six boxes of trash, four or five of which contained other broken down boxes and one containing trash and anything of weight. (TR.91). Mrs. Gregg was unable to move the last box, despite her attempts to kick it and push it. Before she knew it, Mrs. Gregg was falling backwards and staggered six feet before hitting the door. (TR. 91). She described the hit as "very painful" and she reported the accident and went home. Mrs. Gregg returned to work after the weekend and was sent to the clinic because she continued to have significant pain. (TR. 92).

Mrs. Gregg testified that prior to the October 15, 1993 injury her back was feeling great and she engaged in regular activity. Ms. Gregg admitted that she had back problems while she

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[1] Also at issue is medical treatment and expenses incurred from March 1996 to the present.

was in boot camp, however after a period of rest, she resumed her regular life's activities. (TR. 93). Mrs. Gregg reported back problems to Dr. Foltz in 1992 and underwent a strengthening program for her spondylolythesis. As part of her strengthening program. Mrs. Gregg was able to do crunches pain free prior to October 15, 1993. (TR. 95).

With respect to relocation, Mrs. Gregg testified that each time she and her husband moved she experienced "temporary" problems with her back however, she has had consistent pain since the October 15, 1993 work injury. (TR. 95).

Mrs. Gregg was referred to Dr. Kahanovich by the insurance company. Initially Dr. Kahanovich administered physical therapy and then performed surgery on Mrs. Gregg's back. A battery and some hooks were inserted into Mrs. Gregg's back. She eventually returned to moderate duties but never full duty. (TR. 96). Her limitations included standing/sitting capabilities, weight restrictions and limitation of overhead lifting and heavy repetitive lifting.

Mrs. Gregg testified that she was employed at a convenience store as an audit control clerk following her work injury. (TR. 100). She described this position as easier than her pre-surgery job. As time went on, her duties increased and the job became more difficult. For example, she was required to bag orders and engage in increased bending and lifting. After several months Mrs. Gregg was in such severe pain that her husband would carry her from her car to the house because she was unable to walk. (TR. 101). Mrs. Gregg had also resorted to walking with the assistance of a cane. By the time Mrs. Gregg stopped working at the convenience store, her pain was a "10" and her left leg would "drop dead" and she had no control over it. Finally, Mrs. Gregg told her employer, through Bill Griner, that she could not work anymore because they were asking too much of her and she was in too much pain. (TR. 102). Mrs. Gregg worked through severe pain because she does not give up or like to let her situation get her down. (TR. 103).

Mrs. Gregg was seen by Dr. Henrickson who spent more than twenty minutes with her and asked her to bend over and touch her toes. According to Mrs. Gregg, just because she can bend over and touch her toes does not mean that it does not hurt and she told Dr. Henrickson that she was in pain. (TR. 104). Mrs. Gregg had to have the clips removed from her back because they were causing so much pain. She then began treating with Dr. Dahl at the pain clinic. There she underwent physical and used a TENS Unit. (TR. 106). Mrs. Gregg noted that Dr. Meeter may try to fuse the left side of her back because the first procedure failed. Mrs. Gregg testified that at the time of the hearing she was experiencing the most pain to date. She was seeing Dr. Keller for coping with stress and pain. (TR. 108).

Mrs. Gregg finally testified that she has wanted to return to work and has attempted to do so since relocating in Hawaii. However, the longest she has worked has been less than three months due to the pain that she experiences when working. (TR. 109). Mrs. Gregg experienced intermittent back pain between 1991 and 1992.

Mrs. Gregg was deposed on June 11, 1993. (EX 44). Mrs. Gregg testified that she developed back pain in 1991 when she was scrubbing floors for five and one-half hours in the Rehabilitation Unit of the United States Marine Corps. Mrs. Gregg testified that she was in a car accident in 1984 which caused an injury to her upper back. Mrs. Gregg was prescribed Motrin following the accident for approximately four to five years. Mrs. Gregg was discharged from the Marine Corps due to spondylolisthesis, grade 1. Mrs Gregg was told to exercise by her family physician, Dr. Foltz. She complied with his directive and after exercising she "got back to a hundred percent." (TR. 42). She explained that she was able to hike, camp, canoe, mountain bike and carry on an active life. Mrs. Gregg testified that on October 15, 1993, she was taking out the trash at work and the heaviest box would not move. Her hands slipped off the box and she went staggering back and fell back first into a door handle.

Mr. David Gregg (hereinafter "Mr. Gregg") testified that prior to the October 15, 1993 accident his wife participated in activities without complaint of pain concerning her lower back. Specifically, Mr. Gregg described an upper back injury which Mrs. Gregg suffered in 1984 but which never prevented her from doing anything. Prior to the injury, Mrs. Gregg was able to participate in bowling, camping, mountain biking and canoeing. (TR. 133-134). Prior to the injury, Mrs. Gregg also engaged in the normal everyday chores of being a housewife. Since the injury, Mr. Gregg described his wife as participating in no activity as she is in pain even when she is in bed. (TR. 137). Mr. Gregg testified that since his wife's first surgery in 1994 they have had a very low quality of married life since Mrs. Gregg is always in pain and has no joy. Mr. Gregg does not believe that his wife's current medical problems are the result of boot camp since that problem resolved. (TR. 139). Rather, Mr. Gregg attributed his wife's current problems to the surgery performed by Dr. Kahanovich. According to Mr. Gregg, Employer sent his wife to Dr. Kahanovich who performed the surgery and "messed her up." (TR. 139).

B. MEDICAL EVIDENCE

1. Testimony/Medical Report of Dr. John Henrickson

The September 30, 1996 medical report of Dr. Henrickson is contained in the record at EX 34. Dr. Henrickson took a history through discussion with the Claimant and review of records prior to her arrival. On the day of the examination, the Claimant stated that she had been doing very well, so much so that she had begun running errands for her supervisor which required that she run up and down the stairs. With this activity, the Claimant's back pain increased. Claimant subsequently underwent fusion surgery at L5-S1. The Claimant's chief complaint was in the right midthoracolumbar area and in the mid-lumbar area bilaterally. Claimant described it as "aching pain with numbness." Claimant indicated that she could not stand for very long. Claimant had no symptoms referable to the peroneal nerve.

The physical examination revealed normal gait without disturbance. There was skin sensitivity to light touch over the left low back and in the right thoracolumbar parapspinous area. There was no palpable muscle spasm. Dr. Henrickson noted referred pain from the left low back

into the left buttock and left lateral thigh. There was no radicular pain with repetitive forward flexion. Nerve stretch tests were negative for leg pain. Motor and reflex functions were intact in the lower extremities with good strength, specifically in the extensor hallucis longus and plantar flexors bilaterally. Dr. Henrickson noted that the Claimant did not seem to be in any pain. Dr. Henrickson determined that the Claimant was not a credible historian and relied on her medical records. With respect to her October 15, 1993 injury, Dr. Henrickson classified it as a "temporary" injury of contusion to the left low back with no neurologic symptoms. He further determined that such an injury would resolve within days. Finally, Dr. Henrickson determined that the injury did not cause any disruption of the L5-S1 motion segment and in no way necessitated the subsequent surgery in 1994.

Dr. Henrickson determined that there is no scientific basis for relating the Claimant's condition to the October 15, 1993 injury, which is long resolved, nor was there any objective palpable findings of myofascial pain syndrome or dysfunction upon examination. Dr. Henrickson found only "minimal findings of spinal dysfunction." Finally, Dr. Henrickson stated that any further treatment, such as physiatry, would constitute over treatment. Dr. Henrickson recommended a home exercise program that includes extension exercises, as these did diminish her pain upon examination. Dr. Henrickson recommended cessation of all pain medications being taken by the Claimant.

Dr. John Henrickson testified at the August 20, 1998 hearing in this matter. (TR. 18-90). Dr. Henrickson testified that he is a neurosurgeon who runs a longevity anti-aging clinic through which he sees complex neurosurgical consultations. He estimated his participation in Independent Medical Examinations (IME) at one to three per week. Dr. Henrickson's qualifications are contained at EX 46. Dr. Henrickson testified that he performed an IME on Mrs. Gregg on September 30, 1996, the purpose of which was to distinguish between the injury of October 15, 1993 and the underlying chronic condition of Mrs. Gregg's spine and also to assess the need for medical treatment. (TR. 20-22). Dr. Henrickson reviewed various records and reports from Drs. Kaan and Chow. He described Mrs' Gregg's history as follows: while in boot camp Mrs. Gregg strained her right hamstring scrubbing the floor for five and one-half hours. Mrs. Gregg also developed left side low back pain (L5-S1 level) which was found to be Grade 1 spondylolythesis.[2] (TR. 24). Dr. Henrickson testified that Mrs. Gregg was rendered symptomatic and disabled as a result of this previously existing condition. As a further result of the floor scrubbing incident, Mrs. Gregg was discharged from the military. According to Dr. Henrickson, Mrs. Gregg was receiving medication for back and leg pain up until the time of the October 15, 1993 work injury. (TR. 25). Dr. Henrickson reviewed the February 28, 1991 MRI scan of Dr. Foltz, and although Mrs. Gregg complained of pain in her back and down her leg, the MRI scan was negative.

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[2] Dr. Henrickson described spondylolythesis as one bone slipping forward onto the sacrum. He further described a fracture in the area bilaterally which occurs in early childhood.

Dr. Henrickson described the October 15, 1993 injury of Mrs. Gregg as follows: Mrs. Gregg was bent forward pulling on a box of trash when she lost her balance and went directly backwards, striking her left upper tail bone directly on a door handle. The October 18, 1993 Supervisor's report shows a contusion at the left lumbar, left lower back.[3] (TR. 35). Dr. Henrickson further noted that the neurological exam was negative as was the straight leg raising test (used to detect nerve root irritation.). (TR. 35). Dr. Henrickson testified that Mrs. Gregg's October 15, 1993 work injury resolved by October 22, 1993 and therefore, there was no aggravation of a pre-existing injury. (TR. 36). He further stated that Mrs. Gregg's underlying spondylolythesis condition was not aggravated in any permanent way by the October 15, 1993 injury.

Dr. Henrickson disagreed with Dr. Kahanovich that Mrs. Gregg suffered from no significant symptoms from her back up until the October 15, 1993 work injury. Dr. Henrickson further testified that Mrs. Gregg was doing well and undergoing physical therapy until she was required at her job to run errands up and down the stairs at which time she suffered "another work aggravation." (TR. 44).

Dr. Henrickson conducted a series of tests on Mrs. Gregg which revealed that leg raising pain was centralized in the back with no myofascial pain elements. (TR. 47). Dr. Henrickson did note, however, an area of nerve root irritation at the L5-S1 level which was irritated from Mrs. Gregg's pre-existing condition and surgery. (TR. 48). Dr. Henrickson testified that this area will remain irritated for the rest of Mrs. Gregg's life or it will go numb. (TR. 48). For treatment Dr. Henrickson suggested that Mrs. Gregg continue with the exercises taught to her at the St. Mary's Spine Stabilization Program. Dr. Henrickson concluded that any treatment that Mrs. Gregg received after his examination would not be reasonable and necessary.

Dr. Henrickson believes that because the October 15, 1993 injury was a contusion, no further treatment is necessary and the body must be allowed to heal itself. When asked whether Mrs. Gregg needs treatment for back pain Dr. Henrickson replied, "I can't say because I don't know what's happened since then." (TR. 52). By this Dr. Henrickson meant that he had not examined Mrs. Gregg since 1996 and therefore could not determine whether she needed treatment in 1998. (TR. 53).

Dr. Henrickson found that the back surgery could have been necessary as a result of the job injury as well as the repetitive lifting event from January to February 1994. Dr. Henrickson admitted that he had not performed a fusion since sometime in the 1980s because he does not want to pay the malpractice premiums. Dr. Henrickson also agreed that since his exam took place one year before Dr. Kaan's exam, Dr. Kaan is in a better position to evaluate Mrs. Gregg's current complaints. (TR. 62). Dr. Henrickson could see no reason why Dr. Chow's opinion would not be competent, although he had not reviewed Dr. Chow's deposition. Dr. Henrickson did not disagree with Dr. Chow's conclusion that pain management may be helpful for

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[3] Dr. Henrickson described a contusion as a compression of soft tissue or a bruise.

Mrs. Gregg. Finally, Dr. Henrickson stated that in order to more accurately account for Mrs. Gregg's current condition, he would have to evaluate her presently. (TR. 77).

The Curriculum Vitae of Dr. Henrickson is contained in the record at EX 22 and 46. Dr. Henrickson is board certified in neurological surgery.

2. Report and Deposition Testimony of Dr. Gregory Chow

The June 5, 1998 report of Dr. Chow is contained in the record at EX 39. Dr. Chow noted a history of lower back injury while moving a box at work. Claimant's complaints at the time of Dr. Chow's examination included lower back pain from approximately L3-5 which extends up the spine and extends to the posterior aspect of the right leg into the lateral aspect of the leg. Claimant had pain all the time and described it as "someone taking a hot letter opener and sticking it into the left side of my spine." On the right side she described the pain as "pulling sensation." Claimant reported that bending increased her lower back pain.

On examination, Claimant was moving fairly comfortably, although she did not bend or twist at the waist. She complained of pain with light touching and asked that no significant palpation be done to her lumbar spine. There was no visible spasm and sensation was intact with the exception of a subjective decrease along the inner medial aspect of the right calf and approximate L-5 distribution. Claimant subjectively complained of low back pain with pain radiating down into both legs. Objective findings were decreased range of motion of the lumbar spine with essentially normal neurologic stats. Dr. Chow diagnosed failed back surgery syndrome, status-post L5-S1 fusion for spondylolysis and spondyloloisthesis, possible complete fusion left side L5-S1, chronic pain syndrome, and possible bipolar psychiatric disorder. Dr. Chow determined that the prognosis was poor.

Dr. Chow determined that the etiology of Claimant's back condition was multi-factorial. First, he determined she had a classic failed back surgery syndrome. Dr. Chow related the Claimant's symptoms to her pre-existing condition as well as her work injury. As to further treatment, Dr. Chow determined that further treatment from an orthopedic spine rehab and pain management standpoint would not likely result in any significant improvement for the Claimant. However, he determined that chronic pain management, psychiatric care and possible physiatry may be the most useful measures. Dr. Chow did not find the Claimant to be a good candidate for further surgery. Dr. Chow believed the most important treatment to be psychiatric counseling management of any psychiatric disorders and chronic pain management. Finally, Dr. Chow determined that the Claimant reached the point of maximum medical disability.

Dr. Chow noted that prior to the October 15, 1993 injury, although Claimant complained of pain, she was not impaired from activities. Dr. Chow determined that the Claimant could return to work, however her activities would be significantly limited. He further noted that Claimant's work restrictions are permanent. Dr. Chow concluded that the Claimant's current condition is primarily caused by her industrial accident and subsequent surgery. He apportioned

20% of Claimant's condition to her pre-existing condition and 80% to her industrial accident and subsequent treatment.

The videotaped deposition of Dr. Gregory Chow is contained in the record at EX 21. Dr. Chow testified that ninety (90%) percent of his practice is clinical, i.e. treating patients, while ten (10%) percent or less is forensic, i.e. for legal purposes. Dr. Chow is board eligible, however he is not yet board certified. Dr. Chow described a sub-specialty in orthopedics, specifically, spine disorders. (TR. 9). Dr. Chow indicated that although he does not have a specific recollection of his examination of Mrs. Gregg, he does have an independent recollection of Mrs. Gregg. Dr. Chow noted that he was never told why he was asked to examine the Claimant in addition to all of the other physicians that had previously examined her.

Dr. Chow reviewed medical reports and records of Mrs. Gregg, including the report of Dr. Henrickson. Dr. Chow described Dr. Henrickson by his reputation. Speaking of Dr. Henrickson, Dr. Chow stated, "I know that he's a neurosurgeon who doesn't really do very much neurosurgery, if any at all anymore, and that he basically does...forensic work." (TR. 14).

Dr. Chow testified that his opinon remained the same as in his June 5, 1998 report. Dr. Chow described the Claimant's pre-existing back condition as spondylolysis or a stress fracture of the lower portion of the back which sometimes causes pain and sometimes does not. Dr. Chow saw no evidence that this condition had disabled the Claimant from work prior to her October 15, 1993 injury. The condition, according to Dr. Chow, predisposed the Claimant to have more pain and problems with her back upon experiencing trauma. (TR. 18). Dr. Chow described the Claimant's symptoms upon her return to work as "An aggravation of both the pre-existing and the industrial injury." (TR. 21).

Dr. Chow made a series of diagnoses of the Claimant's conditions. First, he diagnosed her with failed back surgery syndrome, meaning she underwent back surgery and has not gotten any better and in fact in some way has actually gotten worse. (TR. 22). Dr. Chow further stated that but for the pre-existing condition and industrial injury, Claimant would not have had the back surgery and would not have failed back surgery syndrome. Dr. Chow also diagnosed possible incomplete fusion, meaning that a gap exists on one side of the Claimant's spine. Dr. Chow further diagnosed chronic pain syndrome, used to describe patients who have prolonged and persistent complaints of pain. Dr. Chow also believed that the Claimant exhibited some fairly typical characteristics of someone with a bipolar psychiatric disorder. Dr. Chow related these symptoms to the problems that the Claimant is having with pain. Dr. Chow believes that Dr. Rinzler, a physiatrist, would be a reasonable referral for the Claimant and someone who could help her by administering a fairly comprehensive pain management program. (TR. 29).

Dr. Chow explained that the Claimant is not a candidate for further surgery due to her diagnoses. Patients with diagnoses such as the Claimant's do not do well with surgery and Claimant demonstrated severe anger following her first surgery. Although Dr. Chow speculated

that the Claimant is suitable for sedentary to light work, he also determined that she would need a functional capacity evaluation before returning to work. (TR. 32).

3. Chart Notes from Naval Medical Clinic, Quantico, Virginia

The treatment notes for Ms. Gregg from the Naval Medical Clinic in Quantico, Virginia, dated October 19, 1993 through August 31, 1995 are contained in the record at CX 1 and EX 19. The treatment notes document Claimant's occupational injury and the course of treatment for the injury. The notes also show a history of chronic back pain as well as leg and neck pain.

4. Medical Reports of Dr. Neil Kahanovitz

On March 4, 1994, the Claimant was examined by Dr. Neil Kahanovitz. (EX 20). Dr. Kahanovitz reported historically that the Claimant had been well until October 15, 1993 when she fell backward, striking her back against a door bar. At the time, she experienced acute onset of lower back pain which increased in December while doing inventory at work. At the time of the exam, Claimant was working as an inventory stocker, which involved bending and lifting constantly throughout the day. The Claimant noted some bilateral radicular pain into the lower extremities, primarily the left.

The Claimant was seen by Dr. Kahanovitz on April 14, 1994. (EX 20). Claimant reported an improvement in her condition with a decrease in her lower back pain. Dr. Kahanovitz determined that the Claimant should be able to return to work with a lifting restriction of 20 pounds as well as a one hour time limit on standing in one place at one time. Claimant was instructed to avoid repetitive bending and twisting. Claimant was further instructed to continue with her home exercise program.

On June 9, 1994, the Claimant returned to Dr. Kahanovitz and stated that she was having great difficulty doing light duty at work due to persistent back pain. Since Claimant had failed to improve with ongoing conservative care, Dr. Kahanovitz recommended her for L5-S1 fusion with implantation of electrical bone growth stimulator and postoperative immobilization in a TLSO with a thigh piece.

On June 14, 1994, Dr. Kahanovitz offered a report, stating that the Claimant's need for surgery is a direct result of her injury of October 15, 1993 in which she was injured while taking out the trash. He further stated that the incident aggravated a pre-existing condition which had not been symptomatic and had not hampered her from pursuing her normal activities. Dr. Kahanovitz said that despite a long trial of conservative treatment, the Claimant continued to do poorly and was unable to pursue her regular activity without increased pain.

On July 6, 1994, Dr. Neil Kahanovitz performed a bilateral fusion L5-S1, left posterior iliac crest bone graft and implantation of electrical bone graft stimulator. (EX 20).

On August 18, 1994, Dr. Kahanovitz saw the Claimant for her six week post-op visit. (EX 20). Claimant stated that her back pain had resolved completely. Claimant continued to wear a back brace with a thigh piece and the x-ray showed that the bone graft was in place with no further slippage. Dr. Kahanovitz recommended removal of the thigh piece with continued usage of the back brace.

The September 22, 1994 report of Dr. Kahanovitz indicates that the Claimant was complaining of pain in her leg as well as in the area of her battery. (EX 20). X-rays showed good healing of the fusion. Dr. Kahanovitz recommended that the Claimant refrain from any bending or lifting during the weaning period when she stops wearing her brace and return in six months.

On January 5, 1995, Dr. Kahanovitz saw the Claimant for her six month post-operative examination. The Claimant was relatively asymptomatic, except for back pain after long periods of sitting. The x-ray showed that the fusion was extremely solid on the right and still healing on the left. The doctor recommended removal of the battery within the next month and return to work in a sedentary or light duty setting with avoidance of repetitive bending, twisting or heavy lifting. On February 7, 1995, Dr. Kahanovitz removed the electrical bone growth stimulator from the Claimant's back.

The February 17, 1995 report of Dr. Kahanovitz is contained in the record at EX 20. Dr. Kahanovitz noted that the Claimant was feeling well and experiencing no problems. A physical capacity evaluation was scheduled and Dr. Kahanovitz anticipated that the Claimant would return to her previous occupation within four to six weeks, depending on her ability to perform at the light duty level.

The March 4, 1994 report of Dr. Kahanovitz is contained in the record at CX 2. Dr. Kahanovitz diagnosed the Claimant with mild Grade 1 spondylolisthesis with a lytic pars defect at L-5.

The April 21, 1995 report of Dr. Kahanovitz is contained in the record at EX 20. Dr. Kahanovitz saw Claimant who complained of increasing left sided radicular pain from her buttocks to her foot in the week prior to her period. The pain tended to resolve following the Claimant's period and for two weeks following she is relatively asymptomatic. Dr. Kahanovitz referred the Claimant to her gynecologist for possibility of endometriosis, although he determined it to be unlikely. Dr. Kahanovitz also referred the Claimant to have and MRI with gadolinium to rule out the possibility of any nerve root compression.

The April 27, 1995 report of Dr. Kahanovitz is contained in the record at EX 20. Dr. Kahanovitz noted that the results of the Claimant's MRI were normal, except for post-operative fusion changes. He found no evidence of neurologic compression or impingement. He advised continued gynecologic work-up since there was no impingement to explain Claimant's pain.

The May 8, 1995 report of Dr. Kahanovitz is contained in the record at EX 20. Dr. Kahanovitz reported that the Claimant's MRI showed no evidence of disc herniation or neurologic impression. However, Dr. Kahanovitz did note changes related to Claimant's spinal fusion and spondylolitic defect. Dr. Kahanovitz recommended continued routine office visits along with continuation of her home exercise program. Dr. Kahanovitz determined that significant rehabilitation efforts would not likely be necessary. Dr. Kahanovitz finally determined that the Claimant should be able to return to work at a light duty level at any time.

The June 9, 1994 report of Dr. Kahanovitz is contained in the record at CX 3. At the time of the report, Claimant was unable to perform light duty work due to persistent back pain. The report further indicates that the Claimant was a candidate for L5-S1 fusion with implantation of electrical bone growth stimulator.

The October 14, 1994 report of Dr. Kahanovitz is contained in the record at CX 4. The report indicates that the Claimant underwent L5-S1 spinal fusion on July 6, 1994. Dr. Kahanovitz estimated the time of recovery for the surgery to be six (6) to twelve (12) months.

The August 4, 1995 report of Dr. Kahanovitz is contained in the record at EX 20. Dr. Kahanovitz reported that the Claimant had begun taking birth control pills as diagnostic of endometriosis. As a result, Claimant's radicular pain down her left lower extremity became significantly increased. Claimant was reassured that her MRI study was normal with no evidence of any disc or neurologic involvement. Dr. Kahanovitz directed the Claimant to return to her gynecologist.

The September 7, 1995 report of Dr. Kahanovitz is contained in the record at CX 5. At the time of this examination, Dr. Kahanovitz referred the Claimant to neurologist Dr. Stuart Stark.

5. Medical Reports of Dr. Stuart Stark

The November 16, 1995 medical report of Dr. Stuart Stark is contained in the record at CX 6. Dr. Stark diagnosed the Claimant with severe myofascial pain associated with sacroiliac dysfunction of the left side. Dr. Stark recommended a physiatry consultation with Dr. Abe Cherrick in order to consider treatment to reduce the myofascial discomfort.

The February 8, 1996 report of Dr. Stark is contained in the record at CX 8. Dr. Stark recommended continued treatments with Dr. Cherrick, including physical therapy three times per week for one month.

6. Medical of Dr. Abraham Cherrick

The January 2, 1996 report of Dr. Cherrick is contained in the record at EX 32 and CX 7. The Claimant was referred to Dr. Cherrick by Dr. Stark. Dr. Cherrick noted a work injury on

November 4, 1994. On physical examination, Dr. Cherrick noted a well healed surgical scar. On flexion and extension, she had no reported discomfort. There was exquisite tenderness along the parasacral region to the left of the scar. There was tenderness over the SI region. Numerous trigger points and tender points were noted in the gluteus medius, minimis, maximus and piriformis. Straight leg raising did not reproduce symptoms, however knee to chest did exacerbate her pain, as did knee to opposite chest. The neurologic examination was unremarkable, with reflexes and strength intact. No atrophy was noted. The findings were suggestive of myofascial disorder with referred pain. Dr. Cherrick referred the Claimant for myofascial therapy before considering any trigger point injections.

7. Medical Reports of Dr. Thomas McNorton

The June 14, 1996 report of Dr. Thomas McNorton is contained in the record at CX 9 and EX 22. Dr. McNorton examined the Claimant on June 11, 1996 at which time her chief complaints were left low back and lower extremity pain. Dr. McNorton described the Claimant as a pleasant 32 year old woman who suffered a low back injury when she fell into a door while at work on October 13, 1993. Dr. McNorton further stated that the Claimant's pain was initially localized in her low back but subsequently developed stabbing radicular like symptoms in her left lower extremity made worse by movement and accompanied by numbness in her left lower extremity. The examination showed normal station and gait. The sensory examination was remarkable for diminished pin prick and light touch in the distribution of the left deep peroneal nerve. Straight leg elevation was negative.

Dr. McNorton explained to the Claimant that her symptoms were suggestive of an L-5 radiculopathy. He suggested that an EMG/NCV be performed to delineate the site and extent of nerve compromise. Dr. McNorton provided a prescription for Daypro and Tylenol # 3 for the Claimant's pain. He further recommended referral to physiatry and physical therapy and possibly neurosurgery to complete evaluation.

The results of an August 15, 1996 EMG/NCV study are also contained in the record at EX 22. The results showed increased insertional activity and spontaneous potentials in the form of positive sharp waves, waveforms indicative of acute denervation were noted in the L, L-5 paraspinals, L, S-1 paraspinals. Motor unit parameters were of normal duration and amplitude. No polyphasic motor units were present. Motor unit recruitment was proportional to effort. The findings were consistent with mild acute denervation in the left L-5 and S-1 dorsal rami enervated muscles. The motor and sensory nerve findings were unremarkable. The F-wave and H reflex latencies were within expected parameters. The EMG revealed evidence of mild acute denervation in the left L-5 and S-1 roots. The final interpretation was left L-5 and S-1 polyradiculopathy, mild. Neuro-imaging was recommended.

The September 24, 1996 chart notes of Dr. McNorton are contained in the record at CX 10. Dr. McNorton's chart notes show that the results of the EMG study revealed very mild left L5S1 radiculopathy. Dr. McNorton recommended continued follow up with physiatry treatment.

The December 18, 1996 chart notes of Dr. McNorton is contained in the record at CX 11 and EX 22. Dr. McNorton indicated that the Claimant was seen by Dr. Henrickson and recommends a referral to physiatry/pain management as an option for further treatment.

8. Report and Deposition of Dr. Kenneth Kaan - Agreed Medical Examiner

The September 12, 1997 report of Dr. Kaan is contained in the record at CX 12 and EX 35. Dr. Kaan reported that Claimant's 1994 back surgery had failed, leaving her with low back pain. Dr. Kaan recommended further operative intervention and also stated that the Claimant's complaints were related to her work injury of October 15, 1993. According to Dr. Kaan, the Claimant had not reached maximum medical improvement nor has she received pre-injury status. Dr. Kaan diagnosed failed back surgery syndrome with low back pain, with the etiology of the pain remaining unclear. He noted that the Claimant has continuing low back pain, despite a reasonably solid fusion. Dr. Kaan further diagnosed failed back surgery syndrome with left lower extremity pain. Claimant had no evidence of significant nerve deficit. Claimant did have positive sharp waves in her paraspinals.

Dr. Kenneth Kaan was deposed on June 10, 1998. (EX 43). Dr. Kaan testified that his practice focuses upon operative and non-operative treatment of patients. He mainly does trauma and spine work. Specifically, Dr. Kann treats degenerative deformity and traumatic spines. Dr. Kaan further testified that he specializes in orthopedics and his sub-specialty is spine surgery. As to his diagnosis of failed back surgery syndrome, Dr. Kaan testified that this means that the purpose of Claimant's back surgery was to relieve her back pain but her pain continues. He further stated that the etiology of the Claimant's back pain remains unclear. According to Dr. Kaan, it is not uncommon for the etiology of a patient's back pain to be unknown. Dr. Kaan testified that he did not evaluate the Claimant for malingering because he only saw her in his office. Dr. Kaan felt the EMG showed a soft sign of significant radicular disease. Dr. Kaan related the Claimant's current complaints to her October 15, 1993 work injury. He reached his conclusion based upon the history which the Claimant related concerning the October 15, 1993 work injury. Dr. Kaan further stated that his conclusion was not based on clinical testing as this would not tend to prove or disprove the source of the Claimant's complaints. Dr. Kaan concluded that Claimant suffers a permanent disability.

9. Medical Board Opinion of June 25, 1991 - Naval Hospital

The opinion of the Medical Board at the Naval Hospital is contained in the record at EX 25. The Board found the Claimant's physical examination to be withing the normal acceptable limits, except for back abnormalities. The Board further found that the condition of spondylolysis existed prior to enlistment and had it been known, would have been considered disqualifying. The Board determined that the Claimant was physically disqualified in accordance with the "Physical Standards for Enlistment." The final diagnosis consisted of spondylolysis with first degree spondylolisthesis, benign bony lesion distal phalanx, right middle finger (resolved), and right hamstring muscle strain (resolved). The Medical Board recommended that the Claimant be

separated from the United States Marine Corps through erroneous enlistment procedure as a Medical Board Code A. The Claimant was advised to seek further medical attention for her condition following separation.

10. Vancouver Radiologists

The December 12, 1991 report of Vancouver Radiologists is contained in the record at EX 26. Dr. Michael Lewiski x-rayed the Claimant's lumbar spine and determined that her hips were normal. Slight sclerosis of the sacroiliac joints was noted, especially on the left. There was also a slight atypical appearance to the facets of L5, which the doctor determined was suspicious for a pars defect at L5. The disc space was considered borderline. The lumbar spine reveals slight arthritic changes of the sacroiliac joints, especially the left. The study further reviewed slight facet hypertrophy and pars defect. There was no definite evidence of a spondylolisthesis at the time.

11. Southwest Washington Medical Center - MRI Lumbar Spine

The Claimant underwent an MRI of the Lumbar Spine on December 28, 1991. (EX 27). The test revealed no significant neural impingement. The intervertebral discs showed little or no significant contour deformity. The vertebral body alignment, height and signal intensity was normal. It was concluded that there was no evidence of disc herniation or focal neural impingement.

12. Records of Lawrence Foltz, D.O.

The treatment records of Lawrence Foltz, from April 1991 through July 1993 are contained in the record at DX 28. In October of 1991, Claimant appeared before Dr. Foltz complaining of right sided neck pain and associated right sided headaches. Claimant also complained of low back pain, which she referred to as "spondyloloisthesis." In addition, Claimant complained of right shoulder pain over the anterior aspect. The examination revealed tendinitis in the right shoulder, spondyloloisthesis, Grade I by history, somatic dysfunction, cervical, and right sided headaches and neck pain secondary to anxiety. Claimant was examined in November 1991 for ongoing low back pain. Claimant noted exacerbation after cleaning her bathroom. The pain radiated into the buttocks but not into the legs. Dr. Foltz noted diffuse low back pain to pressure with decreased range of motion with forward flexion secondary to her complaint. Claimant was referred to Dr. Spolar for an x-ray of the lumbar spine on December 27, 1991.

Claimant reported on January 7, 1992 with tenderness over the superior aspect of the left patella, most noted in full flexion of the knee. There was no ecchymosis or other abnormality present, nor was there edema of the knee. Examination of the Claimant's low back was unchanged from the last exam. Claimant was instructed to continue with her Motrin for tendinitis and low back pain. Claimant discussed her continuing low back pain with Dr. Foltz on February 26, 1992. Claimant was confused concerning spondyloloisthesis. The exam was unchanged from

results of the previous exam. Claimant demonstrated completely normal range of motion with forward flexion, extension, right and left rotational movements, and right and left side bending at her waist. Claimant was able to heel and toe walk without difficulty. Straight leg raises in both seated and supine positions was negative. There were normal deep tendon reflexes at the knee and ankle, with no evidence of any weakness noted. Low back pain was present with no evidence of disc herniation or focal neural impingement. Dr. Foltz referred the Claimant to Dr. David Guyer.

Claimant contacted Dr. Foltz on May 5, 1992 in reference to work out video that she had just purchased called "Buns of Steel", concerned that it could aggravate her hip problem. The doctor advised that beginning a rigorous exercise program such as this could cause pain.

13. Dominion Physical Therapy

The records of Dominion Physical Therapy of Woodbridge are contained in the record at EX 29. Claimant attended a spine stabilization program in March 1994. She participated in range of motion/flexibility exercises emphasizing strength, endurance, coordination, and functional activity. Claimant was able to tolerate neutral position, supine and standing with mild challenges. The physical therapy center provided a progress report on April 8, 1994. Claimant attended 9 of 9 sessions and was treated with moist heat, electrical stimulation, range of motion, cryotherapy, home exercise program, aquatic program, therapeutic exercise, and a back stabilization program. At the time of the progress report, Claimant noted that the pain was not constant anymore. Claimant also noted increased endurance of activity and decreased pain. The Claimant reported slight improvement in low back flexion. Claimant complained of increased pain after prolonged standing or walking activities. There was also pain with forward flexion activities. Left range of motion was all within normal limits except low back extension. The neurological aspect showed no numbness or tingling down either lower extremity. The diagnosis was spondyloloisthesis with improving spinal stability and trunk strength. The Claimant was instructed to continue with physical therapy 2 to 3 times per week with stabilization, aquatics and trunk reconditioning.

14. MRI of Woodbridge

Claimant underwent an MRI at MRI of Woodbridge on April 25, 1995. (EX 30). The radiologist noted no loss of vertebral body height or intervertebral disc space height. The conus medullaris was at the T12 vertebral body level. There was no evidence of spinal stenosis nor a herniated nucleus pulposus. The nerve roots exit normally in the neural foramen. Dr. Rothfeld noted no evidence of a significant abnormality.

15. Edward G. Alexander, M.D.

The December 6, 1995 report of Dr. Alexander is contained in the record at EX 31. Dr. Alexander noted the Claimant's history of having injured her back in boot camp and underwent treatment for spondylolisthesis. She underwent physical therapy and had resumed all

regular activities. Claimant was doing well until October 15, 1993 when she slipped and fell at work, striking her back against a metal door bar. She experienced pain in the low back which was made worse by lifting and bending. Claimant subsequently underwent conservative treatment and eventually a fusion operation, after which her condition declined. Dr. Alexander's examination revealed complete and pain-free back range of motion. There was some tenderness in the left sacroiliac joint, but no tenderness over the healed scar in the midline. Straight leg raising was negative bilaterally. There was some pain on external rotation of the left hip with the legs crossed over, however hip range of motion was complete and pain-free. Motor and sensory function was intact.

Dr. Alexander concluded that there was no structural defect in the Claimant and after reviewing the films, determined that the fusion mass was solid with no evidence of any motion at L5-S1. Dr. Alexander noted a soft tissue chronic problem with myofascial pain syndrome or fibromyalgia being the best working diagnosis. Dr. Alexander further concluded that the Claimant had "established a chronic soft tissue problem in her low back, and this will take considerable time to get better." Dr. Alexander agreed with Dr. Stark that the Claimant needed to be seen by a physical medicine and rehabilitation specialist, such as Dr. Cherrick. He further noted that the Claimant had not received maximum medical improvement. Dr. Alexander noted that the Claimant was capable of working in a sedentary to light duty capacity lifting occasionally up to 20 pounds, frequently 10 pounds with limited waste bending. Regarding causality, Dr. Alexander noted that the Claimant probably had a pre-existing spondylolysis at L5-S1 since her teenage years. Claimant was recovered from that when she suffered a separate injury on October 15, 1993 which could have superimposed on underlying spondylolysis condition and activated her spondylolisthesis. Dr. Alexander concluded that it is difficult to predict when the Claimant will be completely better, but with appropriate physical medicine and rehabilitation, felt that she could return to at least nearly a pre-injury level of functioning.

Unpaid Medical Expenses

A list of Claimant's unpaid medical expenses is contained in the record at CX 20.

IV. CONCLUSIONS OF LAW

The sole issue to be decided is whether the Claimant's ongoing medical care is reasonable and necessary as a result of her October 15, 1993 work injury.[4] The Claimant argues that her ongoing medical needs are the result of both her pre-existing back condition as well as her work injury of October 15, 1993. Employer, on the other hand, argues that the Claimant has recovered from her October 15, 1993 work injury and any continued medical care is not reasonable and necessary.

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[4] Employer challenges the reasonableness and necessity of the Claimant's medical care beginning in 1996.

It is well established that, in arriving at his or her decision, an Administrative Law Judge is entitled to evaluate the credibility of all witnesses and to draw his or her own inferences and conclusions from the evidence. *Quinones v. H.B. Zachery, Inc.,* 1998 WL 85580 (Ben. Rev. Bd. Feb. 10, 1998). Accordingly, the Administrative Law Judge's credibility determinations will not be disturbed unless they are inherently incredible or patently unreasonable. *Id.; Cordero v. Triple A Machine Shop*, 580 F.2d 1331, 8 BRBS 744 (9th Cir. 1978), *cert. denied*, 440 U.S. 911 (1979).

Section 7(a) of the LHWCA provides that "[t]he employer shall furnish such medical, surgical, and other attendance or treatment, nurse or hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a). In order for a claimant to receive medical expenses, his injury must be work-related. *Romeike v. Kaiser Shipyards*, 22 BRBS 57, 60 (1989).

A claimant has established a prima facie case for compensable medical treatments when a physician finds treatment necessary for a work-related condition. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257-58 (1984). In order for an employer to be liable for a claimant's medical expenses pursuant to Section 7(a), the expenses must be reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). The employer must raise the issue of reasonable and necessary medical treatment. *Salusky v. Army Air Force Exchange Service*, 2 BRBS 22, 26 (1975). The test is whether or not the treatment is recognized as appropriate by the medical profession for the care and treatment of the injury. *Colburn v. General Dynamics Corp.*, 21 BRBS 219, 22 (1988); *Barbour v. Woodward & Lothrop, Inc.*,16 BRBS 300 (1984).

An employer's physician's determination that the claimant is fully recovered is tantamount to refusal to provide treatment. *Slattery Associates, Inc. v. Lloyd*, 725 F.2d 780 (D.C. Cir. 1984). All necessary medical expenses subsequent to employer's refusal to authorize needed care, including surgical costs and the physician's fee are recoverable. *Roger's Terminal and Shipping Corporation v. Director, OWCP*, 784 F.2d 687 (5th Cir. 1986); *Anderson v. Todd Shipyards Corp.*, 22 BRBS 20 (1989); *Ballesteros v. Williamette Western Corp.*, 20 BRBS 184 (1988).

The Claimant testified that despite her pre-existing back condition, she was able to engage in a full panoply of activities prior to her October 15, 1993 work injury. The medical problems and limitations which prevent her from leading an active life have existed continually since October 15, 1993. In addition, Claimant testified that she is now incapacitated and unable to engage in normal activity as she is in constant pain. Claimant's husband corroborated this testimony. In fact, he testified that prior to the October 15, 1993 work injury, Claimant hiked, canoed, camped and carried on the regular activities of being a housewife. Since the October 15, 1993 work injury, Mr. Gregg described his quality of married life as very low because the Claimant is always in pain and has no joy.

Of all physicians who gave testimony, reports, or opinions in this case, only Dr. Henrickson, the Employer's physician, determined that Claimant is fully recovered from her

work injury and that her current condition is not in any way related to her October 15, 1993 work injury. I find Dr. Henrickson's opinions less reliable for several reasons. First, Dr. Henrickson admitted that since he had not examined the Claimant since 1996, some of the other physicians, such as Dr. Kaan, would be in a better position to evaluate the Claimant's current condition. Second, I find Dr. Henrickson's opinion to be contradictory. In his report, Dr. Henrickson determined that no further treatment, including physiatry, was necessary and, in fact, would constitute over-treatment. On the other hand, in his deposition, Dr. Henrickson stated that he would agree with the other physicians that pain management could be helpful for the Claimant's condition. Because Dr. Henrickson has been inconsistent and because he has not examined the Claimant in more than two years, I find his opinion insufficient to show that Claimant's medical treatment is no longer reasonable and necessary.

Dr. Kaan, an agreed medical examiner, determined that the Claimant's current complaints are related to her October 15, 1993 work injury. Because she continues to suffer pain and symptoms, treatment remains necessary. Dr. Kaan was frank in his admission that it is difficult to assess the exact etiology of the Claimant's back pain. He further stated that this not uncommon with respect to back pain. I am inclined to rely on the opinion of Dr. Kaan, the medical examiner agreed upon by the parties to this action.

In further support of Dr. Kaan's determination, I turn to and rely upon the opinion of Dr. Chow. Dr. Chow determined that the etiology of Claimant's back condition is multi-factorial. He concluded that Claimant's symptoms were in part related to her October 15, 1993 work injury and in part related to her pre-existing back condition. Dr. Chow determined that chronic pain management, psychiatric care and possible physiatry could be useful measures in treating the Claimant's condition.

I find the opinions of Drs. Kann and Chow supported by the findings of Drs. Stark, Cherrick and McNorton. Based upon the credible testimony of the majority of the doctors who participated in this case, I find that it is impossible to distinguish how much of the claimant's ongoing medical needs are the result of her work injury and how much is due to her pre-existing back condition. Therefore, I find her treatment compensable under the Act.

V. CONCLUSION

Based on the credible testimony of the Claimant, corroborated by the credible testimony of her husband and fully supported by the medical testimony of Drs. Kaan, Chow, and Kahanovitz, I find that Ms. Gregg's ongoing medical care is reasonable and necessary as a result of her work injury of October 15, 1993. Employer is liable for the cost of all treatment which is reasonable and necessary, including the treatment received since 1996 when Employer refused to pay medical expenses based upon the medical report of Henrickson.

ORDER

IT IS HEREBY ORDERED THAT:

(1) Employer shall pay all outstanding medical expenses incurred since the time Employer challenged the reasonableness and necessity of Claimant's ongoing treatment;

(2) Pursuant to Section 7(a) of the Act, Employer shall continue to pay for all of Mrs. Gregg's continued reasonable and necessary medical expenses arising out of her October 15, 1993 work-related back injury.

(3) Counsel for the Claimant, within thirty (30) days of receipt of this ORDER shall submit a fully supported fee application, a copy of which must be sent to all opposing counsel who shall then have ten (10) days to respond with objections thereto. 20 C.F. R. § 702.132.

MICHAEL P. LESNIAK
Administrative Law Judge

MPL/dmg

Dated: March 23, 1999
Pittsburgh, Pennsylvania